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ABSTRACT

This document is one of seven publications contained in a series of materials for physicians on recognizing, intervening with, and treating adolescent alcoholism. The materials in this unit of study are designed to familiarize the physician with the intervention process as it may be used in the treatment of adolescent alcoholics. Both the intervention process and associated issues related to physician decision-making and to communications between the physician and the patient and his/her family are presented. This unit of study will enable the physician to: (1) recognize common defenses used by alcoholics and the characteristics of each defense; (2) list emotional and behavioral patterns exhibited by patients which are associated with resisting treatment; (3) identify personal attitudes which can interfere with the treatment of the adolescent alcoholic; (4) decide on personal approaches regarding ethical issues of confidentiality necessary to facilitate therapy; (5) develop at least one approach to telling parents that their child has an alcohol-related problem and anticipate possible parental reactions; (6) determine the relationships between parental alcohol use and adolescent alcohol abuse; (7) explain the details of formal intervention; and (8) identify key issues in monitoring and following the alcoholic adolescent. (NB)

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Adolescent Alcoholism:
Recognizing, Intervening, and Treating

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Adolescent Alcoholism: Recognizing, Intervening, and Treating

4 Intervention with the Dependent Adolescent

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Introduction

Working with alcoholic adolescents can at times be frustrating and emotionally draining; alternately, it can be challenging and rewarding. Physicians must learn to minimize the former and maximize the latter. The dynamics a physician is likely to encounter when informing the adolescent and his family of a diagnosis of alcoholism can be staggering. Issues related to confidentiality, follow-up, and securing services for economically disadvantaged youth all must be understood. Specific types of interventions must be selected. The physician's role in the intervention process and patient/physician communication must be carefully planned and executed.

Goal

The goal of this unit of study is to familiarize the physician with the intervention process as it may be used in the treatment of adolescent alcoholics. This unit of study presents both the intervention process and associated issues related to physician decision-making and physician-patient/physician-family communications. This unit provides the knowledge base from which the physician may proceed in securing a successful treatment relationship with the adolescent alcoholic.

Objectives

Upon completion of this unit of study, you will be able to:

1. *Recognize common defenses used by alcoholics and the characteristics of each defense.*
2. *List emotional and behavioral patterns exhibited by patients which are associated with resisting treatment.*
3. *Identify personal attitudes which can interfere with the treatment of the adolescent alcoholic.*
4. *Decide on personal approaches regarding ethical issues of confidentiality necessary to facilitate therapy.*
5. *Develop at least one approach to telling parents that their child has an alcohol-related problem and anticipate possible parental reactions.*
6. *Determine the relationships between parental alcohol use and adolescent alcohol abuse.*
7. *Explain the details of formal intervention.*
8. *Identify key issues in monitoring and following the alcoholic adolescent.*

Defenses Used by the Alcoholic Adolescent

Chemically dependent individuals rarely have adequate recognition of their disease unless they have been successfully involved in treatment. Many defenses are used.

Recognition of chemical dependence is hampered by a system of defenses that allows the alcoholic to continue drinking despite overwhelming evidence that the disease is present. It is not unusual for an alcoholic to continue drinking even when faced with ill health, expulsion from school, loss of employment, etc. What are some common defenses used by alcoholics and what are their characteristics?

Webster's defines denial as a "refusal to believe, accept, or embrace." With respect to the alcoholic, this refusal allows him to continue a pathological relationship with a mood-altering substance without regard to consequences. Alcoholic denial, however, is not merely a simplistic rejection of reality, but a complex system that operates within the individual and his or her family and friends.[1,2]

As an individual, the chemically dependent person substitutes a relationship with chemicals for relationships with other individuals. To the extent that the relationship with chemicals is cemented and reliable (e.g., I know when I use alcohol I will feel less pain), personal relationships diminish. The most important relationship for the adolescent alcoholic is not with his friends or family, but with alcohol.

The relationship between an individual and mood-altering substances often begins quite subtly during adolescence. Since adolescence is a developmental period marked by a penchant for new experiences and experimentation, it is common for teenagers to experiment with mood-altering substances. Frequently, such experimentation occurs at parties and social gatherings. Some adolescents may find that alcohol and other substances facilitate their interactions with peers. Before having a few drinks, a teenager may be too shy to participate socially; however, after drinking he may interact quite smoothly and confidently. If an individual repeats this sequence again and again, a positively reinforcing relationship with alcohol slowly builds. The primary context in which the adolescent has learned to interact socially is one in which he is high on alcohol. If this individual were required to remain at a party without drinking, he may find that a number of functions that were learned while drinking (i.e., assertiveness skills, interpersonal communication skills, dancing, etc.) cannot be comfortably performed while sober. This phenomenon is known as state-dependent learning. Activities learned under the influence of a mood-altering substance are often best recalled and repeated while under such influence.[3] Take away an adolescent alcoholic's drinking and you will take with it a host of learned social and interpersonal skills. Obviously, an adolescent who relies so heavily upon alcohol or other mood-altering substances will not readily agree to a diagnosis of alcoholism.

Another factor facilitating denial in teenage alcoholics is omnipotence. Adolescents, especially males, frequently do not see themselves as vulnerable to illness, bodily harm, or the effects of mood-altering substances. Hence, there is considerable risk-taking, and subsequent accidents, occurring during the teenage years. An excellent example of this is automobile fatalities. Auto accidents are the primary cause of death of individuals between the ages of 15-24 years.[4] Research has consistently shown that between 45 and 60 percent of all fatal accidents involving a young driver are alcohol related.[5] However, many adolescents simply believe that "It can't happen to me." They believe they can drink five or six beers and still be capable of driving safely. The chemically dependent adolescent believes he or she can consume a fifth of liquor per day and not be alcoholic. Alcoholism is for others, and so are alcohol-related accidents.

An adolescent's denial of alcoholism is frequently perpetuated by friends.[6-11] A teenager's drinking patterns are usually reflected in peer group associations. Heavy drinkers tend to be friends with other heavy drinkers, abstainers with other abstainers. When an adolescent is told he or she has a drinking problem, peer-related denial will frequently occur. When the youth thinks of the drinking patterns of his friends, he sees patterns similar to his own (View/Discuss Video IV). It is hard for the adolescent to imagine that he has a drinking problem because his friends also would have the same problem. They all couldn't be alcoholics, could they?

Families may participate in the denial process, and other members may well have a similar problem.

Families may also participate in an adolescent alco-

holic's denial system. Some parents do not want to believe their son or daughter is "alcoholic." They may view alcoholics as skid-row bums and alcoholism as an affliction rooted in the lack of willpower. Or, they may not believe that teenagers can be alcoholics. In many instances, parents collude with the adolescent to establish other reasons for the drinking problem — pressure at school, sibling rivalry, parental discord, poor choice of peer-group, etc. Almost anything will do, but not alcoholism! Such parents need to become familiar with the addictive process and the disease model of alcoholism. They may benefit from the ongoing support and education found in such groups as Alanon.

If parents are particularly resistant to accepting the diagnosis of alcoholism in the adolescent, parental substance abuse could be an underlying factor. Research has consistently demonstrated a relationship between parental drinking patterns and those of their offspring.[12-17] An alcoholic adolescent is more likely to have a parent with a drinking or drug problem than a nonalcoholic adolescent. It may be quite difficult to convince an alcoholic father of his son's drinking problem unless the father has addressed his own alcoholism. Thus, parental substance abuse is an important factor that should be considered with all substance-abusing adolescents, and especially when parental denial is encountered (View/Discuss Video I).

Denial can be expressed in many ways. Often, an individual may attempt to minimize the extent of his drinking problem or rationalize the consequences suffered as a result of drinking. With adolescents, this minimizing and rationalizing frequently take the following forms:

- "I'm under a lot of pressure since my parents got divorced. If they would just stop fighting, I'd be able to cut down on my drinking."
- "It's hard to avoid drinking when you're in high school since everybody is doing it. When I'm older, it will be easier to cut down."
- "Ever since I broke up with my boyfriend, I've been drinking a little too much. I'll be able to get my act together, though, once I put him out of my mind."
- "Drinking helps me relax. Maybe I overdo it sometimes, but practice makes perfect. In time I'll learn to be a better drinker."
- "The police in this town have been out to get me from the moment I started driving. Plenty of people my age drink and drive, but I'm the one who gets caught twice in the same month. It's not a coincidence."
- "Not much has been going right for me lately. Having a few drinks helps me get a more positive attitude."

In each of the above examples, the adolescent is denying a problem of alcoholism.

It is important to remember that although the reasons for drinking and the adolescent's self disclosure are important and should be given attention, the primary problem is alcoholism. The reasons for the denial are different; however, these differences are not trivial and should not be taken lightly. Within each individual's statements, concerns or problems which are being experienced are revealed. It is important for the physician to be able to recognize the patient's concern and to express this recognition to the patient. Empathy and understanding are important factors in helping motivate adolescents to seek treatment. At times, adolescents may do for an understanding adult what they would not otherwise do. For example, students will usually work harder for teachers they perceive as warm and engaging than for teachers they perceive as indifferent and cold. But, until and unless chemical dependence is addressed, the adolescent is unlikely to make headway with other problems he or she is experiencing.

Emotional and Behavioral Response to the Diagnosis of Alcoholism

When giving the diagnosis of alcoholism, the patient's behavior should be seen in the context of an individual whose lifestyle and relationships are being threatened by an outsider.

When an adolescent is told that he or she is alcoholic, a number of emotions are likely to be triggered. There is no simple "typical" response (View/Discuss Video X). Common responses include confusion, disbelief, anger, sadness, relief, guilt, and fear. The physician should keep in mind that the adolescent may be hearing for the first time that he is alcoholic and may therefore be somewhat confused or astounded when presented with this diagnosis. Thus, it is helpful to have time reserved to discuss the full implications of the diagnosis and to respond to the adolescent's questions or reactions. If such time is not

available, the diagnosis should be given during another visit when there is ample time for discussion.

When informing an adolescent of the diagnosis of alcoholism, the physician should anticipate the possibility of a negative or hostile reaction. The adolescent may raise his voice, curse, and become agitated; or conversely, become withdrawn, sullen, and uncommunicative. In either case, a good deal of pressure is brought to bear on the physician. The proverbial messenger is being "killed." During these times, it is important to remember that the emotions expressed are an initial and sometimes "knee jerk" reaction, and not necessarily reflection of the adolescent's true feelings about the physician.

Passive-Aggressive Behavior

Anger, frustration, fear, and other such emotions are often expressed through inactivity or passivity. The teenage patient may react to being told he is alcoholic by displaying one or more passive-aggressive behaviors. These behaviors are, in part, an effort by the patient to push the physician away. Because such behaviors are designed to interrupt the physician-patient relationship, they are frequently quite trying.

A common passive-aggressive behavior that sometimes occurs immediately after the diagnosis is given is silent defiance. The teenager may refuse to talk or respond to the physician or may give one-word answers. Rather than ending the interview and/or deciding to talk with the patient at a later date, the physician should continue to give information relevant to the diagnosis of alcoholism. Usually, some of this information will be heard and understood by the adolescent even though his dismeanor appears otherwise (View/Discuss Video III).

Occasionally, an adolescent will react to being told he is alcoholic with unquestioned confirmation and agree to take all necessary steps to address the illness. However, this behavior may not extend past the office door. "I'll agree to anything now . . . just let me out of here!"

Another version of the above behavior is a passive compliance that extends beyond the office into treatment. Although the teenager is outwardly going through the "appropriate" motions, there is little motivation or energy behind his actions. This type of patient is among the most difficult to engage in treatment and often will fare poorly.

The physician may find that following the diagnosis of alcoholism, the adolescent patient will begin to miss follow-up appointments. When an appointment is missed, the physician should reschedule as soon as possible. If appointments are repeatedly missed, it may be helpful to involve the parents, other relatives, or school personnel in helping the adolescent get to the physician's office. Visiting the adolescent at home is also an alternative. If the adolescent continues to avoid appointments, a formal intervention should be seriously considered. This type of intervention will be discussed in a following section.

Aggressive Behavior

The initial reaction of the adolescent to the diagnosis of alcoholism, although unpredictable, is the beginning of the treatment process.

Some adolescents will react to the diagnosis of alcoholism by acting out — cursing, yelling, or threatening. Such behavior may, in part, be an attempt to manipulate or control a perceived threat. For example, "If you send me to treatment, I'll run away." The young person may have many preconceptions about the nature and treatment of alcoholism; thus, a careful, sensitive explanation of the disease model and the importance of treatment should be given. It is helpful to emphasize that any approach to treatment depends upon the cooperation and participation of many people who are important to the adolescent. The adolescent should understand the diagnosis of alcoholism does not mean isolation or being "shipped off" to treatment, but rather an effort involving many concerned persons to address a disease process.

At times, an adolescent may become so distraught with the diagnosis or with the thought of impending treatments that the threat of suicide will be used. "If you send me to treatment, I'll kill myself." "I'd rather be dead than alcoholic." Whenever suicidal ideation or threats persist, they must be taken seriously. While it is beyond the purview of this unit of study to address assessment of suicidal risk, such an assessment should be undertaken whenever the possibility of suicide is an issue. A psychiatric or behavioral consultation may be appropriate in this situation.

More direct acting out, such as yelling or cursing, should be handled with a forthright approach. The physician should recognize the difficulties in hearing for the first time that one is alcoholic; yet, be straightforward and firm about limiting inappropriate behavior.

It is perfectly normal for an adolescent to have powerful feelings when he is first told of being alcoholic. Negative reactions to the diagnosis are often a transitory first step in treatment and not a reflection of longstanding feelings toward the physician (View/Discuss Video VIIa).

Confidentiality

Since the use of mood-altering chemicals poses significant risk to the adolescent's physical and emotional well-being, it is not only the right but it is the duty of the physician to inform parents of adolescent chemical usage.

Most physicians learn early in their education the ethic of confidentiality regarding information disclosed during the course of patient-physician interactions.[18] In the field of dependency, there are particularly stringent federal regulations regarding confidentiality which disallow the disclosure of any information regarding the patient without the patient's consent except in the case of emergencies.

In the case of chemically dependent adolescents, however, there are overriding issues to be taken into account. First, in the strictest legal sense and most obviously, parents are responsible for their children until the age of emancipation or until a court has removed this responsibility from them. Parents, therefore, have the right to insist that their adolescent child, if found to be chemically dependent, enters treatment (View/Discuss Video VIIb). If the adolescent refuses to go in spite of parental insistence, the parents may petition the court to have the adolescent taken forcibly to treatment. While this extreme measure is not generally necessary, it can be held as a last resort approach, should it be needed. Unlike parental rights regarding topics such as birth control, the right of parents to intervene in the case of chemical dependency is not widely challenged.

The reasons for acceptance of parental right to be informed about and to intervene in the case of a chemically dependent adolescent are found in the medical profession's acceptance of alcoholism as a disease as well as the fact that alcohol and nonprescribed drug consumption are illegal for adolescents. Since the use of mood-altering chemicals poses significant risk to the adolescent's physical and emotional well-being, it is not only the right but it is the duty of the physician to inform parents of adolescent chemical usage. Adolescent patients may feel betrayed by a physician's decision to inform their parents. The physician must be very clear with the patient and the parents about the risk of mood-altering chemical consumption. It is usually preferable to inform the adolescent that his parents will be told about the physician's concerns. The physician can anticipate protests from the adolescent and must be prepared to be both firm and understanding when processing the adolescent's reaction.

Informing Parents

The approach to informing parents about a child's chemical dependency is comparable to that employed when informing them of other serious diseases. A professional, factual, nonjudgemental, nonmoralistic position is ideal.

Alcoholism, like any other serious disease, must be communicated to the adolescent and to the parents in a professional, factual, nonjudgemental, and nonmoralistic fashion. This approach tends to minimize defensive parental responses, although it probably will not eliminate them entirely. Parental reactions can vary from disbelief to relief, with anger projected at the physician, a not infrequent occurrence. It is important for the physician to remember that lurking under the surface of these reactions is the pain of guilt, inadequacy, and fear. Parents are often quick to blame themselves (consciously or unconsciously) for their child's chemical dependency (View/Discuss Video VIIc). Some parents believe that it was something they did or failed to do that resulted in their child becoming chemically dependent. Because of these predictable reactions, the physician must be prepared to reassure the parents with several facts:

1. Chemical dependency is a disease which is neither caused nor cured by parental interventions.
2. Chemical dependency is a very treatable disease when treated early.
3. Chemical dependency is a primary disease; that is, no headway can be made with other problems the adolescent may be experiencing until the chemical dependency is addressed.
4. Chemical dependency is a family disease. It is therefore essential to involve the entire family in the recovery process.

5. The risks to adolescents when chemical dependency remains untreated are high; e.g., injury and even death from drinking and driving.

Presentation of the facts about chemical dependency in this manner will give the physician an excellent opportunity to secure the cooperation of most parents in supporting their adolescent child's treatment.

Formal Intervention

A formal intervention is an attempt to create a crisis in the life of a chemically dependent adolescent.

In previous sections, an attempt has been made to describe barriers in adolescents, their families, and physicans which would prevent the chemically dependent adolescent from receiving help. In this section, the formal intervention process will be described, and answers will be provided to the following questions[19,20]:

1. What is a formal intervention?
2. When and why is it necessary?
3. Who should be involved?
4. What is the intervention process?
5. Can an intervention fail?
6. What specifically are the potential roles of the physician in the intervention process?

Formal intervention is the gathering of meaningful persons in the adolescent's life who will be able to present to him or her, in a factual, nonjudgemental manner, the ways in which his or her use of alcohol or other mood-altering chemicals has affected his or her life and the lives of those around him or her. Usually a formal intervention is performed with the assistance of a trained professional, either a counselor, a physician, or other helping professional who works with the family in preparing the intervention. It is important to ask ourselves at this point why a formal intervention is necessary. Why is it not just as effective for a father, mother, friend, physician, or school counselor to one-on-one express concern to the adolescent about his drinking or drug use? In many cases, such one-on-one interventions will have been attempted already, but they will have not been effective. The reason is that it is very easy for the chemically dependent adolescent to dismiss the information presented by a single individual. He has established an elaborate system of rationalizations and alibis to justify his behavior. It is very easy for him to project blame onto others, thereby avoiding the necessity of taking responsibility for his own behavior. Often, family members have information which is unknown to each other. One-on-one, specific items can be easily dismissed, but it is very hard to dismiss facts and information being presented by most or all of the people who are meaningful in the adolescent's life.

The physician often plays a critical role in the initiation of an intervention. It is often the physician who is the first to identify a potential problem or to hear of concern from other family members about a problem in the life of an adolescent patient.

Either by virtue of a longstanding professional relationship with the adolescent or the family or because of the physician's knowledge of medical or other factual data that raise concerns, the physician becomes a meaningful person in the intervention. A meaningful person in the adolescent chemically dependent person's life is anyone close enough to the adolescent that he considers the relationship essential to his self-image. This includes parents, siblings, teachers, school counselors, friends, or anyone else who is concerned and possesses first-hand factual data about the adolescent's use of alcohol or other mood-altering chemicals. It is important to recognize that it may not be appropriate for all meaningful persons to participate in the formal intervention. Those who are unable to view chemical dependency as a disease or who are unable to be nonjudgemental in the presentation of data should not be asked to participate. While an intervention can be successfully done with the physician and one other concerned family member, it is easier for the adolescent to dismiss data from one or two persons as being biased or untrue. Therefore, the more persons involved in the intervention, the more powerful it is. Also, the adolescent may attempt to dismiss data from family members stating that they all have it in for him anyway. It is not so easy to use this defense when data are also being presented by objective outside sources, such as school counselors, physicians, or teachers. Another caveat in selecting participants in the intervention is to evaluate the alcohol or drug use of those persons involved in the intervention. There is no easier way for the adolescent to dismiss the data being

presented than to be able to say that one member of the intervention team drinks or uses as much or more than he does.

The Intervention Process

While it is not always possible to predict the sequence or series of events that surround an intervention, typically a formal intervention is divided into two distinct phases. The first is the pre-intervention phase; that is, those activities which are undertaken to prepare those who are to be participants in the intervention. The second phase is the intervention itself, which can last from a half-hour to an hour or more, depending upon the number of people involved and the complexities of the situation.

A pre-intervention meeting involves gathering family and others to determine the extent of a chemical dependence problem and whether intervention is necessary.

Pre-Intervention

The first thing that usually happens is that concern for the adolescent's use of alcohol or other drugs is brought to the attention of the physician. This could be by the physician's own observations or via contact with another family member. The first task is data collection. Many times there are no direct data about the adolescent's drinking or drug use, but there is concern about the adolescent's behaviors which may be indicative of harmful use. The useful strategy, when there is suspicion that alcohol or drugs are involved, is to request an initial meeting with as many family members as possible who may have had the opportunity to witness drinking or drug use on a firsthand basis. During this initial meeting, other meaningful persons in the adolescent's life can be identified, and their help also can be solicited. The purpose of this initial data collection is to attempt to differentiate normal adolescent rebellion from problems that are directly associated with the adolescent's use of alcohol or other mood-altering chemicals. When the physician has sufficient data to indicate that chemical dependency is a problem, a decision is made about whom should be involved in the formal intervention itself. These meaningful persons are then invited to a preparatory meeting regarding a formal intervention.

The preparatory meeting for an intervention allows family members to discuss the impact of the problem, to obtain facts for use in the intervention, and to determine the details of the intervention and how treatment will be undertaken.

Intervention Preparation Meeting

This gathering of concerned persons can be one of the most important keys to the success of the intervention itself. Often those close to a chemically dependent person have feelings of guilt and fear that need to be dealt with. Parents, for example, might tend to blame themselves for the adolescent's chemical dependency. "If only we were better parents, this wouldn't have happened." Sufficient time must be given for the members of the intervention team to express these feelings and to work through them prior to the actual intervention (View/Discuss Video V).

It is important to use the pre-intervention session to educate the family members about the disease concept for alcoholism and to teach them that they did not cause the disease, cannot control it, nor cannot cure it. It is also important during this session to explore with family members how their lives have been affected by the adolescent's use of alcohol or other drugs. Families often have been unwilling enablers of chemically dependent behavior. They may have covered up for the adolescent or made excuses to others for his behavior, thus enabling the addiction to continue. Sufficient time should be given to exploration of these issues so that family members can begin the healing process themselves. Often in the process of sharing data in this pre-intervention meeting, family members become aware of secrets known only to other family members or friends of the adolescent. This sharing of secrets usually helps to confirm in each participant's mind that the situation is as serious or more so than was originally thought.

When the physician is sufficiently convinced that the members of the intervention team have worked through any reservations, fears, or guilt they may have about the intervention, he should then ask each member of the team to write a list of factual data which are of concern. In the intervention itself, these lists will be presented to the chemically dependent adolescent to allow him to experience the full impact of the cost of his addiction to himself and to those around him. It is important that the lists include facts, not opinions. Facts might include the

following: (1) "I found a marijuana cigarette in your dresser when I was putting your clothes away last Tuesday," (2) "Your grades have dropped," (3) "You are not spending as much time with your friends anymore," (4) "There have been reports that you've been seen drinking after school," (5) "Your girlfriend's parents called and expressed concern that you were intoxicated when you dropped their daughter off after your date last Thursday." Avoid opinions or derogatory remarks, as they will likely increase the adolescent's defenses rather than assist him with seeing the problem clearly. It is important that the data be presented in a loving, nonjudgemental way. The message must be clearly communicated to the adolescent that all parties involved are concerned about what the disease is doing to him, and how their lives have been affected also.

There are many other details which need to be discussed and resolved at the pre-intervention session. One is where to hold the intervention. Whenever possible, it is advisable to hold the session in surroundings that are not entirely comfortable for the adolescent, such as the school counselor's office or the physician's office. It is also crucial for the intervention team to have determined, in advance, what type of treatment the adolescent will be asked to enter. Where a significant amount of resistance is anticipated from the adolescent, the participants may need to determine what the consequences will be if the adolescent refuses treatment. While it is ideal that the adolescent agree to enter treatment voluntarily, the more important objective is that he enter treatment, since parents have the authority to insist that their child enter treatment. This type of coercion may be the final strategy used when attempts to secure the adolescent's cooperation fail.

Treatment will begin immediately after the intervention. It is anticipated that at this point, there will be a crack in the adolescent's defenses, and he will at least be willing to consider the possibility of a problem and the necessity to get some help. A delay in the initiation of treatment often results in the re-solidification of the adolescent's defenses and the loss of the willingness to get help. Therefore, those planning the intervention are advised to be in contact with the treatment center of their choice, to have made reservations for the adolescent to enter the treatment center on the day of the intervention, to have packed a suitcase for the adolescent, and to be ready to transport him to the treatment facility immediately following the intervention.

Intervention Phase

A tremendous amount of work has gone into preparing the intervention, and now the day has arrived. The participants are gathered, and last-minute details are gone over regarding what is about to happen. The adolescent enters the office and is both surprised and confused, as well as perhaps dismayed at the gathering of people in front of him. The person who is coordinating the intervention, either the physician or a counselor, invites the adolescent to come in and sit down and tells the adolescent that everyone is there because they love him and are concerned about him. It is, at times, a useful strategy to ask the adolescent for his cooperation in not interrupting each of the team members as the data are presented. The adolescent must be assured that he will be given the opportunity to respond after all of the data are presented. Then in the order which was pre-arranged, each of the participants presents the list of factual data which he or she has prepared. In organizing the intervention, it is advisable to have those persons with the most powerful data to present last. The adolescent is then told by the intervention coordinator that a treatment program has been selected and asks the adolescent if he is willing to enter treatment. The adolescent usually complies, even though reluctantly. In case the adolescent is still unable to see the problem, the intervention coordinator may choose to summarize the data again in an attempt to convince the adolescent that treatment is the only viable option. Again, it does not matter that the adolescent is not entirely willing to enter treatment. The important issue is that he goes (View/Discuss Video VI). It then becomes the job of the treatment center to work with the adolescent's resistance and to help him become willing to embark upon a program of recovery.

There is always concern about the possibility of failure of the intervention; that is, the adolescent may storm out of the room, run away, or physically resist entering treatment. While these occurrences are relatively rare in a well-coordinated intervention, the possibilities do exist. It is important for the intervention team to remember that even if the adolescent does not enter treatment, a healing process has begun. Since everyone now knows what everyone else knows, and everyone is in agreement that treatment is the only viable alternative for the adolescent, the enabling process will continue; the pressure to seek help will always be a feature of future interactions with the adolescent. As a last resort, contracting with the adolescent may be attempted. This means getting the adolescent to agree to enter treatment

if his attempts to control his drinking or drug use fail in the future.

Intervention Alternatives

While the above sequence of events is typical of the intervention process, there are alternatives. At times, family members and other significant persons attend a series of preparation sessions with the objective of their performing an intervention without a physician or counselor present. These sessions are usually held in conjunction with a chemical dependency treatment program. Typically, a trained counselor coordinates the intervention and assists the family with not only the actual intervention process, but also with the selection of an appropriate treatment facility, making reservations, insurance verification, and other important details.

There are several potential roles which a physician can assume in the formal intervention process. Some physicians may wish to be trained to the point where they can coordinate the entire intervention. While the intervention process is not difficult to learn, it is advisable for a physician who desires to coordinate interventions to participate in several formal interventions prior to attempting to coordinate one. A natural opportunity to participate in an intervention may arise when a physician becomes concerned about the alcohol or drug use of an adolescent patient and asks or is invited to be a member of an intervention team.

Finally, there are some physicians who, because of time constraints or personal preference, may choose not to be a formal part of an intervention, but who wish to be a source of data to the adolescent during an intervention. For this purpose, a personal letter is advisable which outlines the physician's concerns and which can be read to the adolescent at the time of the formal intervention.

Monitoring and Following-Up with the Alcoholic Adolescent

There is a growing body of evidence suggesting that an individual who has been chemically dependent can never again safely use mood-altering substances.

If an adolescent enters treatment for chemical dependency, the physician should ask routinely about alcohol use or use of other mood-altering substances. If during or following treatment, the patient uses any amount of alcohol or other substances, this use should be taken as a signal of continued chemical dependency. Thus, marijuana use or use of any other mood-altering substance during/following alcoholism treatment should be viewed very seriously. Such use places patients at high risk for continued chemical dependency.

It is not uncommon for a young person to report using "small amounts" of alcohol or drugs "now and then" after treatment for alcoholism. Under such circumstances, low-use patterns can quickly revert to abuse or dependency. While the adolescent may want to believe that low levels of use are safe, the physician should not enter into collusion with this misconception.

There may be instances in which, despite the physician's best efforts, the chemically dependent adolescent does not enter treatment. In such cases, it would be helpful for the physician to talk with the patient during each visit about the need for treatment, and, of course, to continue to convey the seriousness of the problem to the patient's parents.

Physicians may have to aggressively obtain an inpatient treatment program for an adolescent from a family with poor insurance regarding chemical dependency or with few financial resources.

Physicians should be especially sensitive to the economic factors involved in the treatment of alcoholism. Intensive treatment, such as inpatient or day-care programs, can be quite costly. Unless the adolescent's family has third-party reimbursement for such services or has significant savings, the cost of these programs can be prohibitive. Unfortunately, there is a dearth of intensive treatment programs for economically disadvantaged patients. Children under 18 whose families cannot afford hospitalization for chemical dependency must rely upon outpatient services or be placed on a waiting list for a "charity bed" in a for-pay facility. Unfortunately, professionals serving indigent youth have come to understand that these "charity beds" are a euphemism for long waits with little hope of admission.

It is clear that the indigent patient faces special

difficulties in receiving services necessary for the treatment of chemical dependency. It is therefore almost axiomatic that the economically disadvantaged patient who is alcoholic will need the physician's help in securing intensive treatment. Such help may range from informing the patient of referral options and securing an initial appointment to taking a strong stand as the patient's advocate with a given agency or institution.

One of the more subtle ways physicians may secure services otherwise denied to economically disadvantaged patients is to approach facilities to which the physician has referred paying patients. In light of the previous business given the facility and implied future business, the physician can request a "courtesy" bed. Often, for every five or six paying patients, it will be possible to receive services at a reduced price or without charge for an indigent patient. Of course, such arrangements are entirely informal and depend upon the initiative, assertiveness, and resourcefulness of the physician.

In rare instances, drinking and use of other mood-altering substances may subside without treatment. In this event, curtailed use should be corroborated by the patient's parents, school personnel, employer, etc. It is important to keep in mind that such patients remain at high-risk for chemical dependency. This risk should be addressed during clinical visits, just as one would check individuals at high-risk for other medical problems, such as diabetes and high blood pressure. Important collaterals, such as family members and school personnel, should be made aware of the possibility of further substance use and encouraged to contact the physician at the first sign of drinking or drug taking.

The most important factor in monitoring and following-up the adolescent alcoholic is coordinated communication.

It is often helpful to have someone clearly designated to be responsible for case management. This person may be the physician, school guidance counselor, a social worker, psychologist, or minister. The primary role of this individual should be as a clearinghouse for pertinent patient information and to convene meetings when circumstances so warrant. Coordination of information and efforts are essential to quality care for the alcoholic adolescent.

Summary

This unit of study has addressed some important attitudes, skills, and strategies the physician may employ in intervening with alcoholic adolescents. Common defenses used by persons diagnosed as being alcoholic were highlighted, with special attention given to denial systems. Emotional and behavioral responses to the diagnosis of alcoholism were reviewed. Issues related to confidentiality and informing parents were presented, and the processes involved in formal and informal interventions were explained. Finally, the importance of monitoring and follow-up were stressed, highlighting special problems encountered by economically disadvantaged patients. It is hoped that this serves as a springboard to further learning and investment in the assessment and treatment of chemically dependent adolescents.

Evaluation

Arranging or becoming involved in the intervention process is the most crucial component of a physician's interaction with an adolescent alcoholic. Careful planning is a must. Now that you have learned about the intervention process, you are prepared to develop treatment plans for an adolescent alcoholic. So that you may assess the effectiveness of your planning and involvement in this process, keep a treatment diary on several of your patients. As you prepare this diary, do the following for each patient:

1. Record your diagnosis.
2. Record the details that led you to make the diagnosis, including
   a. physical findings, and
   b. psychological/social findings.
3. Make a list of persons you contact to gain additional information about the adolescent alcoholic's situation and what information they were able to provide.
4. Make a list of persons you feel are necessary to contact regarding the adolescent's problem and indicate why they need to be contacted. Be sure to include the adolescent on your list.
   (Before you make your contacts, discuss the information in 1 through 4 above with a colleague familiar with treating alcohol dependency. Use the input to help you prepare for the contacts you have indicated in 4. Also seek suggestions for developing the necessary treatment plans.)
5. Make the contacts you indicated in 4. Record the reactions of the persons you contact and how you handled those reactions.
6. Develop your treatment plan. If you are going to use outside resources, list those resources and indicate why they were selected.
   (Again, consult a colleague familiar with the treatment of alcohol dependency. With that individual, carefully review and revise your treatment plan. Record the suggestions.)
7. Implement treatment plan.
8. Monitor your patients' progress, even if they are being treated by others.
   (After you feel the treatment process is progressing well [or poorly] and is at a stage sufficiently advanced to evaluate, review the whole care [diagnosis, treatment, and follow-up] with one or more colleagues.)
9. Prepare a short case study of your patients. List the things you feel went well, and those things you would do differently.
   (To obtain the full benefit of keeping a treatment diary on your teenage alcoholic patients, it is essential that you review each case with colleagues in detail, just as you would do with other cases which present difficulties in diagnosis and treatment.)

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